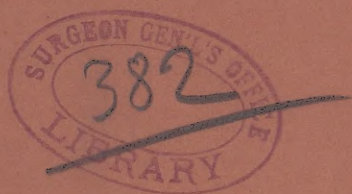


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for external urethrotomy x x



ON SOME OF THE INDICATIONS
FOR
EXTERNAL URETHROTOMY

WITH A CASE OF
UNUSUAL DIFFICULTY.

BY
L. BOLTON BANGS, M.D.

Surgeon to St. Luke's and Charity Hospitals,
New York.

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ON SOME OF THE INDICATIONS FOR EXTERNAL URETHROTO- MY WITH A CASE OF UNUSUAL DIFFICULTY.

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IT is generally conceded by surgeons that the operation of external urethrotomy when aided by an instrument in the urethra to serve as a "guide" to it, and to the bladder, is usually one of the simplest in surgery; but it is conceded also that *without* this guide the operation may be very difficult and even formidable. It is true that there are certain difficulties to be met with in either class of cases. In the first class they may be overcome with slight effort, and in the second, they are to be and can be mastered with a liberal use of time, patience and ingenuity, but they are never to be regarded as insurmountable. Many of the cases which ultimately require this operation I believe to be the result of neglect or of imperfect treatment in the earlier stages of the strictures, and as we come to a better realization of the possibility of this, there will be fewer of these to deal with. In treating of this subject the text-books necessarily make use of generalizations and, in my opinion, overstate (unconsciously, no doubt) the difficulties of the operation. The inexperienced are thus rendered still more timid and fear to put in practice measures which, if employed early, are easily performed, but which, if delayed till pathological changes have taken place, become more or less arduous and perplexing. Notwithstanding the apparent difficulties in a given case, the operation may be undertaken with confidence when it is indicated, for the results are often brilliant, but, on the other hand, life-long damage and even death may ensue from any attempt at temporizing. Admitting all that can be said in regard to the simplicity and ease in general of the operation "with a guide," cases will be met with in which

the associated conditions render the operation one of peculiar difficulty, and hence it may become necessary to qualify some of the foregoing remarks.

The following case, kindly referred to me by Dr. Henry D. Joy, Physician to the Sailors' Snug Harbor, is offered in illustration of this. The patient is an energetic, large and robust man, aged 59. He has always been temperate and, with the exception of his genito-urinary troubles and an injury to one leg, always well. He had his first and only gonorrhœa over 40 years ago, and after an average acute stage, it lasted as a gleet off and on for about eight months. During the war his left thigh and hip were injured by a splinter from the side of his ship to such a degree that he recovered with complete (bony) ankylosis of the hip joint and partial of the knee joint. No symptom of any damage to, or interference with, the urinary organs at that time could be obtained from him. About twenty years ago he had a sudden retention of urine, coming on without any cause that he can remember, while he was in good health, and not being obliged to urinate oftener than three times a day. A Spanish doctor told him that he had a "lump in his rectum." The retention was relieved after a few hours by internal medication only. After that he was as well as usual and remained so till about five years ago, when he felt pain in the left buttock, and became aware of a tender "lump" there. At the same time he began to have frequent and painful urination, as often as every half-hour, night and day, and but little urine was passed each time. He kept at work five or six days longer, although he felt "feverish and miserable," and then went to the hospital, where the "lump" was declared to be an abscess. This was opened after some delay and several ounces (17) of pus were discharged. The frequent urination, pain, etc., continuing, the following day another incision was made in the median line of the

perineum, which he thinks was also "swollen," and pus and urine escaped. In about a month he was well enough to return to his work, but urine continued to pass by these openings as well as by the penis at each act of urination. He kept at work but always had frequent urination—sometimes as often as every hour, night and day. About two years ago two new abscesses appeared in the perineum, discharged spontaneously and left two additional fistulæ for the escape of urine. Ever since then he has been obliged to squat down when urinating because the bulk of the urine passes by these unnatural channels and only partially by the penis. The frequent urination has persisted up to the present time and each act is very painful. He is almost worn out with loss of sleep and suffering. Five months ago he was obliged to stop work and only lately sought relief at the Snug Harbor. On examination the following conditions are found: The left thigh is slightly flexed and firmly fixed in a state of adduction, so that the knee is nearly in contact with the lower third of the right thigh. It is therefore impossible to obtain a complete view of the perineum, but that which is in sight is enormously thickened and distorted and seems like a yellowish-white cushion between the thighs. Its surface is wrinkled by the folds into which the skin has been forced, and is scarred by a long cicatrix and by the old and recent fistulæ, around whose openings the skin is deeply puckered. There are the evidences of nine fistulæ, four of which are now open and discharging. There is also an old abscess extending downward and backward for three inches into the left gluteal region. The integument over it is thin and livid in color and pus can be expressed from its cavity. It is impossible to give in words a picture of the peculiar appearance which the parts present. The condition of the urethra is as follows: the meatus admits No. 30 f. (French); at $\frac{3}{4}$ of an inch from the meatus is a stricture of No. 21 f.; at $4\frac{1}{4}$ inches No. 19 f. is ob-

structed, and behind this point only a fine filiform whalebone bougie can be passed after much effort. The operation of external urethrotomy was determined upon and was performed twelve days later. After the administration of ether, the urethra was injected with sweet oil, but, as it escaped from the fistulæ as fast as it was injected, not much aid was got from it. A fine whalebone bougie was then introduced and search made for the passage in the urethra. It was arrested at about $4\frac{1}{2}$ inches and after some minutes of manipulation, apparently passed on into the bladder, but was discovered protruding from one of the fistulous openings in the middle of the perineum. Several bougies were then successively introduced until this track and opening were filled. Then taking a very long and much finer bougie I succeeded, after long and patient effort, in passing it into the bladder. By its aid a small tunneled silver catheter was gently worked through the strictured urethra to the bladder and served as a staff upon which to cut. The staff being confided to an assistant, efforts to place the patient in the usual (lithotomy) position were made and failed because of the unnatural and rigid condition of the left thigh. He was finally brought down so that his buttocks were beyond the edge of the table; the right leg and thigh were strongly flexed and rotated outward, being firmly held by an assistant; while another, standing behind me, held the left leg and thigh in as straight a line with the body of the patient as the rigidity of the limb would permit. In order to make the incisions through the leathery tissues of the bulky perineum, I was compelled to carry my hand beneath the adductor region of the patient's left thigh and to strongly depress the handle of the knife. As the thigh was across the line of vision it was impossible to see into depth of the wound and progress could be determined only by the sense of touch, and the staff seemed to be entirely out of reach of the finger. Finally, by the grating of the point of the knife upon the

staff, it was known that the latter had been reached, and then, by the aid of directors of different sizes carefully introduced, the stricture tissue was divided and this part of the operation finished. The strictures in the penile urethra were then treated by internal urethrotomy and sound No. 36 f. easily passed into the bladder. The various fistulous tracts and sinuses were either laid open and curetted freely or were curetted alone and some of the cavities which resulted packed with iodoform gauze. In order to insure thorough drainage of the bladder, a large sized soft catheter was passed through the wound and tied in. The hyperplasia of the tissues was so remarkable, causing such an extraordinary thickness of the perineum that I was induced to measure (by means of a straight catheter) the depth from the external edge of the wound to the bladder (i. e., the point at which the urine flowed) and it proved to be five inches. Such a distance has probably been met by other surgeons, but I have never before been led to measure the perineum because of its extraordinary depth, nor have I ever seen recorded any such measurements. The patient made a very slow but steady recovery without an unfavorable symptom. There was considerable suppuration accompanying the healing of the various incisions, but his general condition remained good, the painful and frequent urination disappeared immediately and the greater part of the thickening of the perineum *melted* away, but did not entirely disappear. He returned to his work in about three months, able to urinate naturally and not oftener than once in three or four hours.

It will be observed that the features of peculiar difficulty in this case were the obstruction caused by the position of the thigh, and the character of the perineum. The introduction of the bougie which served as a guide, although attended with some difficulty, was by no means as difficult as I have found it in many cases; and yet, notwithstanding the aid afforded

by it, an aid which has often rendered much more formidable cases simple and easy, the operation was laborious and harassing.

A brief analysis of the foregoing history of this patient is instructive as throwing some light upon the indications for external urethrotomy. It seems to me that there were two earlier occasions when this operation could have been done, not only without detriment to the patient, but with a prospect of his entire relief and with a more speedy recovery. The first was when he had the sudden retention of urine and was told by a Spanish doctor that he had "a lump in his rectum." Inasmuch as he had at that time no symptoms of any prostatic or rectal trouble—no frequency of urination nor pain—and that the obstruction to urination came suddenly, I am inclined to the belief that the swelling was in the perineum, say, *near* the rectum, and that he misunderstood the language of the doctor. The swelling was, no doubt, due to a minute escape of urine (extravasation) and was sufficient to compress and close temporarily the strictured urethra. The patient being a temperate, robust man, with vigorous and resilient tissues, easily disposed of this small amount of irritation and speedily recovered from the retention; but the cause, namely, the stricture (and no doubt some thickening of the peri-urethral tissue) remained to effect later on more extensive damage. As I have already argued this question, and elsewhere reported illustrative cases, I must beg leave to refer my readers to a paper read before the New York County Medical Society, April 26, 1887, and to the discussion which followed.* But it may here be safely asserted, that if at this juncture the stricture had been searched for and an operation done, which would not only have radically cured it, but have relieved the perineum, all the subsequent injury would have been prevented. The second occasion to which I refer was about five years ago, up to which time he had remained in ordinary health,

* See Medical Record of May 7, 1887.

when he evidently had more extensive escape of urine behind the strictures and the development of perineal abscesses. Of course it was good surgery to open these and enable the urine and products of inflammation to escape, but it would have been better to have done the organized operation at once instead of taking two days to do an inefficient thing which left the patient, so far as the cause was concerned, as badly off as before. One of the incisions (that made in the median line) would, if carried a little deeper, not only have relieved the bladder and liberated the pus, but have given access to the strictures which could have been treated as usual. Or, if the patient's general condition was such that haste was necessary, the free drainage afforded the bladder by the incision carried through into the urethra, would have prevented any further damage and the more radical treatment of the urethra could have been safely deferred. The further history of the patient shows that after this he was never well, his condition grew steadily worse, and in spite of his heroic efforts, made in order to support his family, he was obliged to succumb. It is possible that the condition of the perineum in such cases as this may cause some to hesitate to perform external urethrotomy. The presence of extravasation of urine and of perineal abscesses may be to some minds contra-indications to its performance, but I claim, and insist upon it, that these conditions form the strongest possible reasons why the operation should be done. What can so speedily relieve the torment of the patient as this, which quiets the expulsive efforts of the irritable bladder and at the same time evacuates the already infiltrated tissues? What else will prevent frightful sloughing and even "death from gangrene?" It may be said in reply that incisions into the cellular tissues and gradual dilatation of the urethra will meet the indications. But will they? The incisions may temporarily relieve the tissues, but not removing the cause, further extravasation may

take place. Dilatation is slow, uncertain and may have to be intermitted. During its progress the cause of the extravasation persists and the latter has time and opportunity to recur. It is not long since that I heard a distinguished teacher of genito-urinary diseases and who *professes* gradual dilatation under all circumstances, deliver a clinical lecture upon two cases in which he had pursued this plan. Following the first attempt at dilatation there was in one case "anuria" for sixty hours, and in the other "anuria" for a less period, and in each such conditions of extremity that (as he said) he "thought that he should be able to exhibit the kidneys of both patients." They recovered with extensive sloughing of the tissues of the perineum, scrotum and groins, but all treatment of the strictures was omitted for several weeks. Furthermore, the following case which is abbreviated from a number of the Virginia Medical Monthly, I quote without remark, believing that I have written a sufficient commentary upon it:—"I found the patient in a very nervous and anxious state, suffering from complete retention of urine, with extravasation of urine, and severe perineal abscess;"—"the diagnosis of complete retention from impassable stricture was determined. The **absence of reliable assistants and the diseased condition of the perineum, and also the considerable extravasation of urine, decided me against external perineal urethrotomy.* The puncture of the bladder per rectum was also decided against and suprapubic puncture being the only means for relief left, was accordingly performed. No aspirator being at hand, a common exploring trocar was used and the urine carefully withdrawn. The canula was plugged with a wooden plug, which was, of course, a very unsatisfactory and even dangerous arrangement. The patient *died from gangrene* about sixty hours after the operation." After this experience the writer invents a trocar and canula!

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*Italics are mine.

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